UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF MICHIGAN

DANIEL D. HOGAN,

Plaintiff, Case No.

v Hon.

AETNA LIFE INSURANCE COMPANY,

Defendant.

____/

BERRY MOORMAN, P.C.
Sheryl A. Laughren (P34697)
Sandro D. DiMercurio (P80704)
Attorney for Plaintiff
535 Griswold Street, Suite 1900
Detroit, MI 48226
(313) 496-1200
slaughren@berrymoorman.com
sdimercurio@berrymoorman.com

____/

COMPLAINT

Plaintiff, Daniel D. Hogan, through his counsel, for his Complaint as against Aetna Life Insurance Company says as follows:

1. Plaintiff resides in the City of Clawson, County of Oakland, and State of Michigan.

2. WPP Group USA, Inc., is an advertising and marketing agency doing business in the State of Michigan, County of Wayne.

3. WPP Group USA, Inc., sponsors a health care benefit plan ("Plan") which is an "employee welfare benefit plan" as defined in the Employee Retirement Income Security

Act of 1974 ("ERISA") § 3(3), 29 USC 1002(3), and an "employee welfare benefit plan" as defined in ERISA § (3)(B), 29 USC 1002(2)(A).

4. Plaintiff is an employee of WPP Group USA, Inc, a Plan participant, or a Plan beneficiary.

5. WPP Group USA, Inc., is the "plan sponsor" of the Plan within the meaning of ERISA § 3(16)(B), 29 USC 1002(16)(B).

6. Upon information and belief, WPP Group USA, Inc., is the Plan administrator and therefore a "fiduciary" of the Plan within the meaning of ERISA §3(21)(A), 29 USC 1002(21)(A).

7. Defendant is a service provider to the Plan that pre-certifies medical services for Plan participants, adjudicates claims submitted by Plan participants and claims administrator to the Plan.

8. In administering claims under the Plan, Defendant exercises discretion and control when providing information to participants during the pre-certification process and exercises discretion and control over the Plan when interpreting the Plan to approve or deny a claim.

9. When providing pre-certification information, Defendant is required to provide complete and accurate information.

10. When adjudicating claims, Defendant is required to follow the terms of the governing Plan documents.

11. Defendant is a "fiduciary" of the Plan within the meaning of ERISA § 3(21)(A), 29 USC 1002(21)(A).

12. Venue is proper in this Court under 29 USC 1132(e) because the Plan is administered in this district, Defendant conducts business in this district, and Plaintiff resides in this district.

13. Plaintiff has a history of multiple surgical excisions and tissue rearrangements for right upper extremity vascular malformation in childhood. He has developed progressive right upper extremity lymphedema with increasing frequency of right upper extremity cellulitic episodes. Despite compression therapy and use of a pneumatic pump he has continued to have upper extremity swelling and requires antibiotic suppression therapy.

14. In October 2015 and December 2015, Plaintiff was examined and underwent testing at the Cleveland Clinic.

15. According to the Cleveland Clinic and Dr. Graham S. Schwarz, M.D., Department of Plastic Surgery, on lymphoscintigrapy his right upper extremity reveals pooling of tracer activity in his right forearm consistent with lymphatic obstruction causing delay. Magnetic resonance imaging shows focal retraction of the skin and subcutaneous tissue on the anterolateral aspect of the proximal upper arm consistent with scarring. Within the volar subcutaneous space of the proximal forearm and throughout much of the anterolateral upper arm there are characteristics imaging representing a combination of scar, focal area of edema and interspersed venous malformation. Further impressions were of serpiginous structures anterior to the elbow.

16. Plaintiff suffers from recurring and debilitating cellulitis infections.

17. After evaluation and assessment, Dr. Graham S. Schwarz, M.D., Department of Plastic Surgery recommended right arm scar revision and lymphaticovenous bypass.

18. On or about November 1, 2015, Dr. Schwarz sought pre-service authorization from Defendant, on behalf of Plaintiff, for the scar revision and lymphaticovenous bypass.

19. On or about November 20, 2015 Dr. Schwarz was advised that Defendant refused to authorize the procedures he recommended and for which he sought pre-service authorization.

20. On April 19, 2016, Plaintiff filed an appeal of Defendants denial of pre-authorization ("Level 1 Appeal").

21. On May 27, 2016, Defendant denied Plaintiff's Level 1 Appeal stating that an "Aetna medical director" reviewed the letter of medical necessity and that (s)he considers the procedures recommended by the Cleveland Clinic and Dr. Schwarz to be "experimental and investigational."

22. According to Defendant's Level 1 Appeal denial letter, Plaintiff's Level 2 appeal was due within 60 calendar days (or August 6, 2016).

23. On July 14, 2016, Plaintiff, through his designated representative, requested Defendant to provide the following:

> "1. A copy of the complete Plan Document;
>
> 2. The Summary Plan Description provided to Mr. Hogan's employer.
>
> 3. Any and all documents which confer a grant of discretionary authority from the Plan Sponsor to anyone else, including Plan Fiduciary(ies) and the Plan Administrator(s), including but not limited to Administrative Services Agreement(s).
>
> 4. A copy of every rule, guideline, protocol, or similar criterion that served as a basis for making the benefit determination;
>
> 5. The identity of each health care professional consulted with in the adverse benefit determination, including those for combination lymphedema, chronic recurrent cellulitis and antibiotic resistance;

and a copy of or detailed description of the information and advice provided by each health care professional;

6. The identity of each medical expert whose advice was obtained on behalf of Aetna in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination; and

7. All documents:

(i) relied on in making the benefit determination, including without limitation, all reports, notes, records, test results, correspondence and curriculum vitae of any independent medical examination/reviewer, functional capacity evaluator, transferable skills expert, and/or vocational expert;

(ii) submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

(iii) that demonstrate compliance with administrative processes and safeguards in making the benefit determination; or

(iv) that constitute a statement of policy or guidance with respect to the plan concerning the denial benefit, without regard to whether such advice or statement was relied upon in making the benefit determination.

8. All notes of telephone conferences with Mr. Hogan or any treating physician or other Health care provider." ("Request for Information").

24. The Request for Information also requested an extension to file Level 2 Appeal to 30 days after Plaintiff's receipt of the information requested in the Request for Information or until September 21, 2016, whichever was later. ("Request for Extension").

25. The Request for Information was sent to Defendant by fax and certified mail return receipt requested on July 14, 2016.

26. Defendant received the fax copy of the Request for Information on July 14, 2016.

27. Defendant signed for the copy mailed by certified mail on July 30, 2016.

28. Defendant never responded to the Request for Information

29. Defendant never responded to the Request for Extension.

30. On August 2, 2016, Plaintiff again requested the information in the Request for Information. "Request for Information 2")

31. The August 2, 2016 Request for Information 2 was sent by fax and contained another copy of the Request for Information.

32. Defendant received the Request for Information 2 on August 2, 2016.

33. Defendant never responded to the Request for Information 2.

34. On August 6, 2016, Plaintiff sent Defendant a letter by certified mail, first class mail and fax, asking Defendant to respond to and provide the information requested in the Request for Information and Request for Information 2. ("Request for Information 3")

35. Request for Information 3 also requested Defendant to extend the time in which Plaintiff had to file his Level 2 Appeal until such time as Plaintiff was provided the information requested in Request for Information, Request for Information 2 and Request for Information 3.

36. Defendant never responded to Request for Information 3.

37. Request for Information 3 also asked that if the extension requested in Paragraph 35 was denied, that Request for Information 3 be considered to be Plaintiff's Level 2 Appeal.

38. Defendant never responded to Plaintiff's request that Request for Information 3 be considered as Plaintiff's Level 2 Appeal.

COUNT I

ACTION FOR FAILURE TO PROVIDE PLAN DOCUMENTS UNDER 29 USC § 1132

39. Plaintiff adopts and incorporates all of the paragraphs above as though fully set forth herein.

40. 29 CFR 2560.503-1(h)(2)(iii) provides that Plaintiff is to be provided copies of "all documents, records and other information relevant to claimant's claim for benefits."

41. Defendant filed to provide the documents as required pursuant to 29 USC 1132(c) and 29 CFR 2560.503-1(h)(2)(iii).

42. As an ERISA fiduciary, Defendant was responsible for providing timely, accurate and complete information and documents to Plaintiff.

43. Pursuant to 29 USC 1132(c), Defendant is liable to Plaintiff for penalties in an amount up to One Hundred Ten ($110) dollars per day from thirty (30) days after the first request for the claims file and supporting documents.

COUNT II

BREACH OF FIDUCIARY DUTY

44. Plaintiff adopts and incorporates all of the paragraphs above as though fully set forth herein.

45. Defendant owed to Plaintiff a fiduciary duty to perform its administrative duties within the utmost loyalty to Plaintiff and solely in his best interest for the exclusive purpose of providing benefits to her

46. Defendant breached its duty to Plaintiff by refusing to allow pre-certification of the procedures determined necessary by the Cleveland Clinic, by failing to provide a reasonable basis in writing to the Plaintiff for it's failure to provide benefits, and by failing to provide Plaintiff a full and fair review of his claim.

47. Defendant further breached its fiduciary duty to Plaintiff by its

a. failure to review and investigate Plaintiff's claim in good faith,

b. failure to comply in good faith with regulations and procedures regarding the proper administration of Plaintiff's claims,

c. failure to engage in meaningful dialog with Plaintiff, his physician and/or his designated representative providing "a description of any additional material or information" that is necessary to perfect the claim,

d. failure to respond to or provide the information in the Request for Information,

e. failure to respond to or provide the information in the Request for Information 2,

f. failure to respond to or provide the information in the Request for Information 3,

g. failure to respond to Plaintiff's request for extension of time as set forth in Paragraph 35, supra, and

h. failure to respond to Plaintiff's request that Request for Information 3 be considered a Level 2 Appeal.

i. The actions of Defendant has denied Plaintiff a proper review of his appeal.

ACTION FOR VIOLATION OF ERISA 503, 29 USC 1103

48. Plaintiff adopts and incorporates all of the paragraphs above as though fully set forth herein.

49. ERISA 503, 29 USC 1103, requires each employee benefit plan to establish procedures to notify "specific reasons for a [benefit]denial, written in a manner calculated to be understood by the participant" and providing a reasonable opportunity for the participant to obtain a "full and fair review" of the benefit denial. These procedures are to be consistent with the regulations adopted by the Secretary of Labor.

50. By its refusal to provide information requested by Plaintiff, failure to respond to reasonable requests for extensions, and failure to respond to Plaintiff's request for a second level appeal, Defendant has violated ERISA 503 and its accompanying regulations.

COUNT III

ACTION FOR BENEFITS

51. Plaintiff adopts and incorporates all of the paragraphs above as though fully set forth herein.

52. Defendant's actions and inactions in the administration of Plaintiff's claim for benefits have been and are unreasonable, arbitrary, capricious and undertaken in bad faith.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff respectfully request this Court grant Plaintiff the following relief:

a. A declaratory judgment as to the Plaintiff's entitlement to authorization for the procedures as requested by the Cleveland Clinic;

b. A order estopping Defendant from challenging Plaintiff's Appeal and requested Second Level Appeal;

c. A judgment awarding Plaintiff prejudgment interest, costs and expenses, including reasonable attorney's fees;

d. An order enjoining the Defendant from further breaches of fiduciary duties, and directing that Defendant exercise reasonable care, skill, prudence, and diligence the administration of the Plaintiff's claim;

e. A judgment awarding Plaintiff an amount representing One Hundred Ten ($110) dollars per day from the date of the original request for documentation until such time as the entire claims file is provided to Plaintiff; and

f. Such other relief as may be deemed just and proper.

Dated: November 21, 2016

Respectfully submitted,

BERRY MOORMAN, P.C.

/s/Sheryl A. Laughren
Sheryl A. Laughren (P34697)
Sandro D. DiMercurio (P80704)
Attorney for Plaintiff
535 Griswold Street, Suite 1900
Detroit, MI 48226
(313) 496-1200
slaughren@berrymoorman.com
sdimercurio@berrymoorman.com